SUGGESTED FORM

Mental Retardation Community Medicaid Services

INDIVIDUAL SERVICE PLAN

MR Case Management - 90 DAY SCREENING

Code: _____

Individual: _____ Medicaid Number: _____

CSB: _____ Provider Number: _____

Case Manager: _____ Telephone: _____

Start Date: _____ End Date:** _____ Quarterly Review Dates: N/A

CASE MANAGEMENT GOAL:		
CASE MANAGEMENT OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES
CASE MANAGEMENT GOAL:		

** Attach a signature page that includes, at a minimum, the signatures of the individual/legal guardian and the provider's responsible staff member.*

** End date cannot exceed 90 calendar days; billing restricted to no more than 3 calendar months.